COLORADO
School Health Services Program

SCHOOL HEALTH SERVICES PROGRAM PROGRAM MANUAL

Section 6

Medicaid Administrative Claiming

The School Health Services Program is a joint effort between the Colorado Department of Education and Department of Health Care Policy and Financing.
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Table of Contents

Section 6: Medicaid Administrative Claiming

Medicaid Administrative Claiming (MAC) offers districts reimbursement for the costs of administrative and outreach activities that support the Medicaid program. MAC reimbursement is made quarterly through a claim that consists of payroll costs for staff that provide direct medical or health related services (Direct Services), administrative and outreach activities. A quarterly Random Moment Time Study (RMTS) is used to determine the percent of time sampled participants spend performing Medicaid allowable administrative and outreach activities. The quarterly MAC claim is calculated by applying the results of the RMTS, district assigned Unrestricted Indirect Cost Rate (UICR) and Medicaid Eligibility Rate (MER) to allowable direct expenditures.

Detailed information on the factors related to a MAC claim can be found in the Web-Based Cost Reporting System Guide (**Appendix A.9**).

6.1 Allowable Activities

- MAC allowable activities include:
- Facilitating Medicaid Outreach
- Facilitating Medicaid Eligibility Determination
- Translation Related to Medicaid Services
- Medical Program Planning, Policy Development and Interagency Coordination
- Medical/Medicaid Related Professional Development and Training
- Referral, Coordination and Monitoring of Medicaid Services

Examples of the above listed allowable activities include, but are not limited, the following:

- Providing information to individuals and families regarding the Colorado Medicaid program and available services.
- Scheduling and/or coordinating EPSDT screens or other medical and mental health diagnostic services.
- Gathering information that may be required in advance of health related referrals.
- Developing internal plans and strategies to improve health service delivery and eliminate gaps.
- Attending a parent meeting for a child with issues that may need outside health or counseling services.
- Observing a child as part of the process for referred students of the intervention and referral services.
- Coordinating a meeting with school staff and parents to determine if mental health or educational evaluations are needed.

Detailed information regarding MAC activities can be found in the Time Study Implementation Guide (**Appendix A.7**).

6.2 Quarterly Cost Report

After the RMTS quarters ends, each participating district must complete and certify a quarterly financial submission (cost report) for staff included in the applicable quarterly RMTS. The primary purposes of the quarterly financial submissions for MAC are to:

- Document the district's total Medicaid allowable staff costs for providing administrative activities and staff related training and transportation costs, including direct costs and indirect costs, based on a federally approved cost allocation methodology.
- Ensure districts report any federal funds so those costs are properly excluded from the allowable cost used in the claim calculation.
- Certify the district's public expenditures in accordance with CRS §25.5-5-318, *et seq.* (**Appendix A.5**)

The financial submission includes the following:

- Payroll information for Direct Services, Targeted Case Management (TCM) and Administrative Services staff listed on the district's quarterly RMTS staff cost pool lists (SPL).
- Medicaid allowable costs associated with MAC related staff travel and training.

Detailed instructions on how to complete a quarterly financial submission can be found in the Web-Based Cost Reporting System Guide (**Appendix A.9**)

6.3 Medicaid Eligibility Rate

The Department of Health Care Policy and Financing (Department), Colorado Department of Education (CDE) and Public Consulting Group (PCG) have established an agreement to allow PCG to calculate the Medicaid Eligibility Rate (MER) often referred to as the October 1 count. With this change the Department will receive student lists directly from CDE to transmit to PCG. PCG will then compare, in a multi-level process, the student lists to the Department's eligibility records. The Districts will be given their ratio and may request back-up documentation. Districts may have an opportunity to contest their ratio. For additional information see the Medicaid Eligibility and Student Utilization Ratio Process Memo issued by the Department (Appendix A.12).

6.4 Reimbursement

Each participating district's quarterly financial submission (cost report) is used to calculate a MAC claim by the Department. In addition to costs identified within the cost report, the MAC claim utilizes the RMTS percentage for each staff cost pool, the district assigned UICR and the MER. Once the claim is calculated, the net reimbursement amount is determined and submitted to the Centers for Medicare and Medicaid Services (CMS) for payment. Districts are reimbursed by the Department for MAC on a quarterly basis.

6.5 Desk Reviews

Prior to the finalization of the quarterly MAC claim, the district's cost report will be reviewed by the Department and its vendor. Districts may be required to answer questions and/or provide copies of documentation to support the information reported on the quarterly financial submission.

6.6 Quarterly Financial Compliance Reviews

Participation in the Colorado School Health Services program requires districts be subject to a periodic MAC Quarterly Financial Compliance Review at least once every three years. This review determines whether the district is maintaining all the necessary financial records to support costs reported for one quarter's MAC claim and resulting payment. The following financial documentation (MUST be cash based) for selected participants on the staff roster for the quarter will be reviewed:

- Documentation of the quarterly *Salaries* paid. (amount and account code)
- Documentation of quarterly *Contracted Staff Costs* paid. (amount and account code)
- Documentation of quarterly *Employer Paid Benefits* paid. (amount and account code)
- Documentation of quarterly *Federal Revenues* paid. (amount and account code)
- Copy of the *latest financial audit from your CPA firm*

Any variance in the documentation provided and the amount shown on the Cost Data reported should be explained.

6.7 Claims Adjustment

If a district requests a financial adjustment to a claim, after a MAC claim has been processed and reimbursed, the request must be made in writing to the Department. In order to process an adjustment that would result in an additional payment to the district, the request must be made within 2 years of the last date of service due to timely filing limitations. The district must ensure that any request to adjust a cost report contains documentation necessary to support the request and that the request is sent to the Department at least 90 days in advance of the expiration date.

The district's request should:

- Specify the cost reporting quarter.
    - Where multiple quarters are impacted, the district must submit a separate financial adjustment request for each.
- Identify the issue or error to be addressed.
- Include documentation in sufficient detail to support the requested adjustment or error.

- Sufficient detail encompasses submission of financial documents, Medicaid match lists for eligibility ratios and supporting work papers or source documentation, where necessary.

The Department and its duly authorized vendor shall determine the adjustment request based on the following:

- New material or evidence, or
- A clear and obvious error, or
- Inconsistent with the law, regulations or rulings.

An adjustment by the Department is not required due to these criteria, but merely permits that action. As such, a conservative view will be approached when considering a financial adjustment and in determining what shall be reviewed. For example, items or evidence that were in, or should have been in the district's possession during the original quarterly administrative claim submission, but for whatever reason were not included, shall not be considered "new" material or evidence.

If the Department accepts an adjustment and makes changes to a finalized document, the Department shall re-issue the district a revised claims certification that outlines the adjustment and identifies the new reimbursement. If the financial adjustment indicates an overpayment of funds the provider shall have 60 days to return the overpayment to the Department.

This policy does not replace a determination made during a state or federal audit to adjust or correct a cost report outside of the 2 year time frame.